Sample ADDENDUM FOR OLDER ADULTS
(Self Administered Health Risk Profile)

Name:_____ **Todays' Date:**_____

Date of Birth:_____ **Age:**_____ **Male:**__ **Female:**__ **SS# or MR#:**_____

Please put a check mark by each sentence that applies to you. If you do not know the answer to a question, put a mark by it and someone will discuss it with you. Your answers to these questions will help your doctors and nurses design a preventive health care plan that will show you how to stay healthy and may keep you from having cancer, diabetes, or even a heart attack or stroke.

Please DO NOT write in the shaded areas

Annual Assessment of Risk Factors	Risk?	Ed. T
1. **Depression** **9** I have been told by a doctor that I am/was depressed. When? _____ Who? _____ **9** My spouse, or a close family member or friend, passed away in the past year. **9** I feel "blue" and tired much of the time, and/or I have problems sleeping and a poor appetite. **9** I have thought about taking my own life. In the past?____ Recently?____ When? _____ **___Does not apply to me.**	**Y N**	
2. **Social Environment** **9** I am the principal care giver for my disabled spouse/partner/adult child with mental illness. **9** I do not have family or friends willing and able to assist me when needed. **9** I do not participate in activities outside my home. **___Does not apply to me.**	**Y N**	
3. **Safety** **9** I have fallen in the past year. How many times?____ Where?_____ Injury?_____ **9** I take medicine prescribed by more than one doctor. **___Does not apply to me.**	**Y N**	

Annual Assessment of Risk Factors	Risk?	Ed. T
4. **Cognitive Function** **9** I need help to take my medicine correctly (the right time, dose, medication, etc.). **9** I need assistance to handle money and pay bills. **9** Someone in my family has/had Alzheimer's Disease. Who? _____ **___Does not apply to me.**	**Y N**	
5. **Activities of Daily Living** **9** I am unable to take a shower or tub bath without assistance. **9** I need assistance to shop, cook and/or eat (e.g., to cut meat or open cans/boxes). **9** I am unable to move about without using a cane, walker or wheelchair. **___Does not apply to me.**	**Y N**	
6. **Sensory** **9** Someone in my immediate family has had glaucoma. Who?_____ **9** It has been more than 1 year since I had my eyes examined. **9** I do not hear as well as I should, and/or I have ringing in my ears. **___Does not apply to me.**	**Y N**	
7. **Nutrition** **9** I have missing teeth or ill-fitting/missing dentures. **9** I have difficulty swallowing or I choke easily. **___Does not apply to me.**	**Y N**	
8. **Elimination** **9** I am incontinent of bladder or bowel, or I have "accidents". **9** I have difficulty starting my urine stream (male). **9** I use laxatives every day or almost every day. **___Does not apply to me.**	**Y N**	
9. **Sexual Intimacy** **9** I have difficulty achieving or maintaining an erection (male). **9** I have vaginal dryness or irritation, and/or sex is painful for me (female). **9** Since I (or my partner) have been ill (ex: heart attack or surgery), I am afraid that it might hurt or cause another heart attack if we have sex. **___Does not apply to me.**	**Y N**	

Notes:_____

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Name:_____ Date:_____

Reviewed with client: _____ Date: _____

(Clinician)